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Notice of Independent Review Decision

**DATE OF REVIEW:** July 22, 2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Physical therapy to include Therapeutic activities (CPT code 97530); Gait training (CPT code 97116); Aqua therapy w/therapeutic exercises (CPT code 97113); E-stimulation (CPT code G0283); Ultrasound (CPT code 97035); and Therapeutic exercise (CPT code 97110).

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

American Board of Orthopaedic Surgeons

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

**PATIENT CLINICAL HISTORY:**

The patient was lifting sand bags at the time of injury on xx/xx/xx when he lifted, twisted, and felt a pop in his lower back.

On his initial evaluation by M.D., the patient complained of lower back pain that radiated

to his left gluteal area, however, not extending into the legs. Of clinical significance, the patient is a poorly controlled diabetic who by these reports does not always take his medication.

In February of 2009, at the request of his treating physician, the patient had a lumbar spine MRI which revealed multilevel degenerative changes in the entire lumbar spine. He had a small extruded fragment/disc herniation at L4-5 and a small foraminal herniation at L5-S1.

In his early course of treatment, the patient had multiple modalities of physical therapy for treatment of his lower back which was treated under the working diagnosis of lumbar strain. The patient had a several month hiatus where he did not return to physical therapy.

In April of 2009, the patient sustained another injury when he fell at home, falling against a wall and fracturing his ribs. In addition to the rib fractures, there has been request for treatment of a cervical and thoracic injury and I believe a knee injury.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

After review of these records, from what I conclude, the patient had a lumbar strain. He had a course of conservative treatment, which included multiple modalities of physical therapy. The only objective diagnostic test that is included in my review is that of a lumbar spine MRI performed in February of 2009, which revealed aforementioned degenerative changes and small disc herniations.

After review of these records, in my opinion, the initial course of physical therapy for the treatment of his lumbar spine injury was appropriate. However, at this time in my opinion, the denied request for physical therapy modalities is reasonable. The patient has shown to be noncompliant. Irrespective of this, during his initial treatment time, the patient should have been instructed in a home exercise program. His failure to comply with this, in my opinion, further stresses that the contested treatment regimen would be of little benefit and falls outside of ODG Guidelines. In summary, I concur and uphold the denial of further physical therapy treatment to include Therapeutic activities (CPT code 97530); Gait training (CPT code 97116); Aqua therapy w/therapeutic exercises (CPT code 97113); E-stimulation (CPT code G0283); Ultrasound (CPT code 97035); and Therapeutic exercise (CPT code 97110).

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)